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An Economic Analysis of Florida's Hospital Certificate of Need Program and Recommendations for Change

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AN ECONOMIC ANALYSIS OF FLORIDA'S HOSPITAL CERTIFICATE OF NEED PROGRAM AND RECOMMENDATIONS FOR CHANGE

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ONE of the social objectives near the top of many agendas is solving the growing health care crisis.[1] Among the goals most often stated are containing the rising cost of health care, and ensuring that everyone receives adequate health care, regardless of ability to pay.[2]

During the 1970s and 1980s, the certificate of need program (CON) gained widespread use as the primary regulatory tool to accomplish these goals.[3] This program basically requires that health care providers receive government authorization before making major capital expenditures or adding additional beds or services.[4] Regulators believed that, without CON, health care providers would not respond to ordinary market forces and would overinvest in beds and services without regard to actual need or demand.[5]

In light of mounting empirical evidence that CON has not accomplished its objectives,[6] the federal government stopped requiring states

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1. *See, e.g.*, REGULATION AND HEALTH FACILITIES, FLA. DEP'T OF HRS, 3 HEALTHY FLORIDIANS, THE 1989 FLORIDA STATE HEALTH PLAN 31 (1989) [hereinafter 1989 PLAN]; CENTER FOR HEALTH POLICY RESEARCH, 2 STATE UNIVERSITY STUDY OF INDIGENT CARE 1.18-.19 (1986) [hereinafter UNIVERSITY STUDY]; Koenig, *With Surgery Comes Post-Op Pain*, FLA. TREND, May 1991, at 61; Resnick, *No Margin, No Mission*, FLA. TREND, May 1991, at 65.

2. 1989 PLAN, *supra* note 1, at 31; Koenig, *supra* note 1, at 61.

3. Schmid & Faas, *Medical Cost Containment: An Empirical Application of Neo-Institutional Economic Theory*, in LAW & ECONOMICS: AN INSTITUTIONAL PERSPECTIVE 179 (1981); Gross, *Certificate of Need: Background and Review of Recent Changes in Florida's Law*, 2 U. FLA. J.L. & PUB. POL'Y 183, 184-186 (1988-1989); Simpson, *Full Circle: The Return of Certificate of Need Regulation of Health Facilities to State Control*, 19 IND. L. REV. 1025, 1025-1033 (1986).

4. Simpson, *supra* note 3, at 1025. Although CON programs vary somewhat in their specifics, those differences are not important for this discussion.

5. 1989 PLAN, *supra* note 1, at 1 ("The major premise underlying the CON Program is that, in its absence, the marketplace for institutional health services is guided by economic incentives for excess investment."); Gross, *supra* note 3 at 184; Simpson, *supra* note 3, at 1028-29.

6. *See infra* notes 102-111 and accompanying text.

to implement these programs,[7] and states began to abandon this regulatory approach.[8] Florida, however, still operates a substantial CON program.[9] It is therefore time to reevaluate Florida's program in light of its economic soundness and recommend new means to accomplish its legitimate objectives if, in fact, the current CON program is not appropriate.

This Comment concludes that Florida should recognize the empirical evidence and acknowledge that CON does not accomplish its cost containment goals. That would leave ensuring adequate indigent care as the only major social objective arguably served by CON.[10] However, CON is not a satisfactory tool for solving the indigent care problem.[11] In fact, some argue that CON actually exacerbates the problem.[12]

By recognizing the flaws in CON and redefining the program and its goals in light of mounting empirical evidence and a changing health care environment, Florida could much better achieve CON's objectives at a lower cost to the government. This Comment suggests a new regulatory scheme that will help accomplish CON's goals by putting market forces into play while recognizing and compensating for wealth effects.[13] The proposed scheme compensates for wealth effects

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7. H. AARON & W. SCHWARTZ, THE PAINFUL PRESCRIPTION: RATIONING HEALTH CARE 5 (1984); Brown, *Common Sense Meets Implementation: Certificate-of-Need Regulation in the States*, 8 J. HEALTH POL., POL'Y & L. 480, 481 (1983).

8. Gross, *supra* note 3, at 185. There have been a surprisingly small number of reports about the effects on health care costs in states that abandoned their CON programs. Those states that abandoned CON shortly after the federal government removed the incentives for these programs did seem to experience at least a short-term increase in investment and some costs. *See* Gross, *id.* at 192-193; Simpson, *supra* note 3, at 1080-81. However, some researchers and commentators believe that the changes in the reimbursement environment that have occurred in recent years diminish the predictive value of those states' experiences and that states that abolish CON in the future will not experience significant increases in capital expenditures. *See* Shannon, *Certificate of Need: Where it has Been and Where it is Going*, MICH. B.J. 592, 596 (1988) (citing Burda, *Hospital Construction Boom Not Expected Despite End of Some State CON Programs*, MOD. HEALTHCARE 6 (Nov. 6, 1987). Also, this Comment's suggestions for redesigning much of the environment in which hospitals operate will help prevent other states' negative experiences from occurring in Florida. *See infra* notes 144-184 and accompanying text.

9. *See* Gross, *supra* note 3, at 185. Florida's certificate of need program is codified at FLA. STAT. §§ 381.701-.7155 (1989 & Supp. 1990) and FLA. ADMIN. CODE ANN. chs. 10-5 (1991) & 10-17 (1986 & Supp. 1989).

10. Simpson, *supra* note 3, at 1030-32. Other purposes are served by CON, such as protecting the bureaucracy that administers the program and protecting the strong, for-profit interests in the hospital industry, but whether those are legitimate social objectives is not considered here. *See also infra* note 15 and accompanying text.

11. *See infra* notes 112-134 and accompanying text.

12. *See* UNIVERSITY STUDY, *supra* note 1, at 1.2.

13. The economic concept of wealth effects is that an individual may place different values on the same right, depending on whether the individual must pay someone else to acquire that

in favor of indigent care providers by giving the providers an entitlement to the initial property rights embodied by CONs and then allowing and encouraging free transfer of the CON property right.

I. HISTORY AND BACKGROUND OF CON

The CON program as it exists in Florida traces its origins to efforts at health planning in the early 1970s.[14] CON was said to have three major goals: controlling health care costs, ensuring quality of care,[15] and ensuring indigent access to medical care.[16] These are basically still the core goals of the CON program in Florida.[17]

In 1975, the federal government enacted the National Health Planning and Resources Development Act (NHPRDA), providing funding

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right or can sell that right in exchange for something.

For example, assume that a factory on a river is given the legal property right to pollute the river. If a down-river homeowner must purchase the right to require the factory to stop polluting the river, that homeowner may be willing and able to pay only $5,000. If it would cost the factory $10,000 to install the technology to stop polluting the river, then the $5,000 offer will not be sufficient, and the factory will continue to pollute. On the other hand, if the initial legal property right to be free from river pollution were given to the homeowner, the homeowner might decide that it is worth $15,000 to keep the river clean and will not sell the right to a clean river for less than that amount. In this scenario, it is more efficient for the factory to install the cleaning technology than to purchase the right to pollute the river.

By assigning property rights in a particular way, the government can favor certain social policies and objectives. In the above hypothetical, if the government wished to favor industry, it would give the factory the legal right to pollute the river without requiring compensation to down-river homeowners. If, however, the government favored nonpollution, it would give down-river homeowners the legal right to compel river clean-ups. In either case, notions of economic efficiency and favoring the highest-valuing user require allowing parties to negotiate and sell their respective property rights. *See* A. POLINSKY, AN INTRODUCTION TO LAW AND ECONOMICS 136-38 (1989); Coase, *The Problem of Social Cost*, 3 J.L. & ECON. 1 (1960).

14. Florida's original CON program was enacted in 1972 by ch. 72-391, 1972 Fla. Laws 1364.

15. Although quality of care is listed as a major objective of CON, this Comment does not discuss that objective in detail. The author believes that the current licensure system, and not CON, operates fairly effectively to ensure such quality and is not inherently economically flawed. *See* FLA. STAT. §§ 395.001-.104 (1989 & Supp. 1990); FLA. ADMIN. CODE ANN. ch. 10D-28 (1991).

16. *See* S. REP. No. 96, 96th Cong., 1st Sess. 7-9 (1979); Simpson, *supra* note 3, at 1028-32; *see also* Gross, *supra* note 3, at 189.

17. According to state regulations:

> The goal of Florida's Certificate of Need program is to promote the orderly development of the healthcare marketplace. The regulatory efforts . . . are aimed at:
> (1) Fostering the timely development of needed health services and facilities;
> (2) Creating a competitive environment for health service development;
> (3) Ensuring the development of high quality and cost-effective services; and
> (4) Fostering access to underserved groups including Medicaid recipients and indigents.

REGULATION AND HEALTH FACILITIES, FLA. DEP'T OF HRS, HRS MANUAL, *Certificate of Need* 1-2 (February 12, 1990).

for the CON administrative mechanisms and conditioning certain federal funds on the enactment of CON review programs.[18] Florida was one of twenty states that already had CON programs in place when the federal requirements were enacted.[19] Forty-two states and the District of Columbia had CON programs when Congress repealed the requirements in 1986.[20] Congress discontinued the CON requirements[21] because of the Reagan Administration's desire to decrease both federal funding for and regulation of many government programs and because of the mounting empirical evidence that CON cost containment objectives were not being realized.[22]

With the federal CON guidelines lifted, Florida reevaluated its program and chose to maintain it, although the legislature did make several changes.[23] Some believed that these changes, while arguably not extremely substantial, would help the program better accomplish its goals.[24] Such an approach has not been unusual, as many policy makers have chosen to disregard the analysts who argue that CON is inherently flawed, and instead act as if the programs are just poorly designed.[25]

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18. Pub. L. No. 93-641, 88 Stat. 2225 (1975); *see also* Simpson, *supra* note 3, at 1042.

19. Gross, *supra* note 3, at 184-85.

20. *Id.* at 185; Simpson, *supra* note 3, at 1025.

21. Pub. L. No. 99-660, 100 Stat. 3799 (1986).

22. L. BROWN, HEALTH POLICY IN THE UNITED STATES: ISSUES AND OPTIONS 15 (1988); Simpson, *supra* note 3, at 1026-27.

23. Gross, *supra* note 3, at 185; the statutory changes were enacted in ch. 87-92, 1987 Fla. Laws 355.

Today the Florida statutes basically require that providers first obtain a CON for the following projects:

1. Addition of new beds;
2. Construction or establishment of additional health care facilities;
3. Capital expenditures of $1 million or more;
4. Conversion from one type of facility to another;
5. Changes in licensed bed capacity;
6. Establishment of a home health agency or hospice;
7. Acquisitions by health care facilities or health maintenance organizations (HMOs);
8. Establishment of or substantial changes in inpatient institutional health services;
9. Most acquisitions of existing health care facilities;
10. Most acquisitions of major medical equipment by a health care facility or HMO;
11. Project cost overruns;
12. Changes in the number of psychiatric or rehabilitation beds;
13. Establishment of advanced tertiary health services; and
14. Transfer of a CON.

FLA. STAT. § 381.706 (1989).

For a good explanation of the details and procedures of Florida's CON program, see Makar, *Antitrust Immunity Under Florida's Certificate of Need Program*, 19 FLA. ST. U.L. REV. 149, 150-154 (1991).

24. *See* Gross, *supra* note 3, at 210.

25. L. BROWN, *supra* note 22, at 45.

II. DEBUNKING THE COST CONTAINMENT MYTH

The primary reason for CON was to help control the rising costs of health care.[26] Regulators believed that market failures[27] at work in the health care industry caused hospitals to overinvest in unneeded and under-used beds and services, thus driving up costs.[28] While some believe that this argument has a strong common sense appeal,[29] implementing CON has not helped control costs.[30] To understand why, one must examine the underlying market failures that existed in the hospital industry during CON's early implementation, changes in today's marketplace that have acted to counteract some of those failures, and empirical studies showing the actual results of CON.

A. Underlying Theories

Several market failures have traditionally affected the hospital industry.[31] These market failures aroused public policy concerns because of the central roles that health care and its spiraling costs have taken in the political agenda.[32] The government determined that health care public policy problems, most notably health care cost containment and ensuring adequate indigent care, would be best addressed through CON.[33]

The underlying market failures and their suitability as bases for regulation are discussed below. It should be noted that some of these market failures have been substantially curtailed in recent years be-

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26. Gross, *supra* note 3, at 189; Shannon, *supra* note 8, at 593. This goal still exists as a primary motivation for Florida's CON program. Makar, *supra* note 23, at 149 ("[T]he regulatory structure of Florida's certificate of need program has evolved over time but has specifically retained economic competition as one of its main objectives.").

27. A market failure is some imperfection that causes a market to operate in other than an economically ideal way, deviating from our notions of how businesses should react to certain economic conditions. *See generally* S. BREYER, REGULATION AND ITS REFORM 15-35 (1982); Feldman, *Health Insurance in the United States: Is Market Failure Avoidable?*, 54 J. RISK & INS. 298 (1987).

28. Gross, *supra* note 3, at 184. One of the foundations of this premise was "Roemer's Law," which argued that physicians will act to fill unused beds, regardless of medical need. Brown, *supra* note 7, at 481 (citing M. ROEMER & M. SHAIN, HOSPITALIZATION UNDER INSURANCE (1959)).

29. *See, e.g.*, L. BROWN, *supra* note 22, at 15 ("Since the early 1970s, agreement has been growing that 'significant surpluses of short-term general hospital beds exist or are developing in many areas of the United States and that these are contributing significantly to rising hospital care costs.'"); *see also Florida Hospitals: A New S&L Crisis*, FLA. TREND, March 1991, at 18 [hereinafter *Florida Hospitals*].

30. *See infra* notes 102-111 and accompanying text.

31. *See infra* notes 35-72 and accompanying text.

32. *See, e.g.*, *supra* note 1, and accompanying text.

33. Simpson, *supra* note 3, at 1037-43.

cause of significant changes, discussed later, that have occurred in the health care market.[34]

1. *Excessive Competition*

The traditional notion of excessive competition is that when prices are set at unprofitably low levels, some firms will be forced out of business, resulting in higher prices being charged by the remaining firms.[35] The traditional excessive competition argument is similar to the most widely stated rationale for CON. Proponents of CON claim that deregulation of hospitals will result in over-investment in unneeded technology and services,[36] resulting in an inability of many hospitals to recover their investments because of lack of demand and the already-slim profit margins of many hospitals.[37] It is argued that the effect will be overall higher prices as those facilities resort to service cross-subsidization in attempts to recover investments.[38] Also, many hospitals may still be unable to survive economically,[39] which will result in the failure of certain hospitals.[40] The undesirable effects of failed hospitals may include decreased access to health care and an increased ability of some remaining providers to charge even higher prices because of the resulting decreased competition.

Excessive competition has been discredited as a legitimate rationale for regulation except when predatory pricing or natural monopoly is a concern.[41] However, even in those cases, regulation is not the preferred solution because the antitrust laws sufficiently address the problem.[42] In the case of hospitals, regulation is not an appropriate solution for excessive competition, because today's market forces will ordinarily act as disincentives for economically inefficient behavior.[43]

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34. *See infra* notes 73-101 and accompanying text.

35. S. BREYER, *supra* note 27, at 29.

36. *See, e.g.*, Gross, *supra* note 3, at 184. Florida does have an oversupply of some health care resources, and these excesses have led to an increase in competition among hospitals. *See* UNIVERSITY STUDY, *supra* note 1, at 1.8.

37. *See* L. BROWN, *supra* note 22, at 15 ("[A] national trend, sharply accentuated in the last year or two, toward fewer admissions, shorter stays, and lower hospital utilization per 1,000 population has thrust many hospitals into general fiscal stress and unprecedented competition for patients."); *Florida Hospitals*, *supra* note 29, (operating margins for Florida's acute-care hospitals in 1989 were 0.4%).

38. *See Florida Hospitals*, *supra* note 29.

39. *See id.*

40. *See id.*

41. *See* S. BREYER, *supra* note 27, at 193-195; R. POSNER, ECONOMIC ANALYSIS OF LAW 337-339, 592 (1986).

42. *See* S. BREYER, *supra* note 27, at 159-161.

43. *See id.* at 195. *See also infra* notes 73-101 and accompanying text.

2. *Moral Hazard*

When consumers do not bear the costs of their own behavior or choices, they have incentives to use more resources and make more expensive choices than they might if forced to pay for those choices.[44] This phenomenon is known as the moral hazard problem.[45] When ethical or other institutional pressures do not adequately solve the moral hazard problem, government regulation may be appropriate.[46]

The health care industry is traditionally one in which moral hazard is a significant problem.[47] For most people, health care costs are borne by private insurers or the government, without any limit on the amount of care that may be purchased or at what cost.[48] For example, by 1983 only 7.5% of hospital fees were paid directly by the patient.[49] The remaining 92.5% were paid by the government, third-party insurers, or not at all.[50]

The problem of moral hazard in the purchase of health care has decreased in recent years as those who are the actual economic purchasers of most health care, the private insurance companies and the government, have begun to intervene in the process and place limits on the amounts they are willing to spend for certain services and on the treatment of certain conditions.[51] However, the moral hazard problem still exists to some extent, because even though some third-party payers are acting to control costs per procedure, patients often still have limited incentives to reduce the number of procedures they actually buy.[52] Increased utilization review by third-party payers has helped to reduce this problem.[53]

3. *Inadequate Information*

The problem of inadequate information arises when consumers cannot compare and make rational decisions based on comparative attributes of different alternatives.[54] With health care, this problem often arises even when full information is made available to the consumer.

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44. S. BREYER, *supra* note 27, at 33.
45. *Id.*
46. *Id.*
47. *Id.*
48. *Id.*; FLA. DEP'T OF HRS, 1990 FLORIDA HEALTH CARE ATLAS 107 (1990) [hereinafter 1990 ATLAS].
49. 1990 ATLAS, *supra* note 48.
50. *Id.*
51. *See infra* notes 73-97 and accompanying text.
52. *But see infra* notes 95-97 and accompanying text.
53. *See* 1990 ATLAS *supra* note 48, at 114, 132; *infra* notes 80-97 and accompanying text.
54. S. BREYER, *supra* note 27, at 26.

The problem is that the consumer is not able to evaluate the information in a way that would allow economically rational decision making.[55]

The Florida Legislature attempted to solve the cost-of-service inadequate information problem through the creation of the Health Care Cost Containment Board (HCCB).[56] One of the duties of HCCB is to publish cost-of-service information about individual hospitals and other health care providers.[57]

There are at least two significant problems with this approach to solving the inadequate information problem. First, the information is often difficult to interpret, as average costs for some services may be higher in one hospital while average costs for other services may be lower in that same hospital. Also, patients are not able to evaluate the information because often they are not aware of what type of care they will need and all of the various factors that will determine the actual cost of that care.[58] The second significant problem is that even if patients were able to evaluate this information, they would not care because of the moral hazard problem.[59] However, concern about the problem of inadequate information as to cost of care is probably decreasing because of the increasing involvement of sophisticated insurance companies and other third-party payers, as discussed below.[60]

When inadequate information actually exists as a market failure, government regulation may be appropriate.[61] Of course, the regulatory remedy must be carefully tailored to address that market failure.[62]

4. *Inefficient Incentives to Overinvest in Certain Services*

Other market failures are not neatly classified into one or more of the above categories. These failures are largely unique to the health care industry and are primarily a combination of inadequate information and inefficiency in the tort system. The result of these failures is that hospitals may feel compelled to overinvest in much of the latest technology—both equipment and services—despite limited economic need for this technology.[63]

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55. *See* Schmid & Faas, *supra* note 3, at 179.
56. FLA. STAT. § 407.01 (Supp. 1990).
57. FLA. STAT. § 407.09 (1989).
58. Schmid & Faas, *supra* note 3, at 179.
59. *See supra* notes 44-53 and accompanying text.
60. *See infra* notes 75-94 and accompanying text.
61. S. BREYER, *supra* note 27, at 28.
62. *Id.*
63. *See* 1990 ATLAS, *supra* note 48, at 106.

Inadequate information seems to be driving patients' desires to be treated in hospitals with the latest and best technology and procedures, even if those are not the services that the patient actually needs.[64] There are two likely explanations for this. First, there may be a "halo effect" in the patients' perception of their hospital.[65] For example, patients may believe that if a hospital performs organ transplants and has the latest in diagnostic imaging devices, then that hospital must be that much better and more capable of performing the routine appendectomy or delivery that the patient actually needs. The second reason is that the patient may want to have the latest and best technology, "just in case." In reality, few of those advanced services are administered on an emergency basis.[66] Thus, if two hospitals are in close enough proximity to be competitors, the hospitals are also likely to be close enough for a patient to receive any advanced care needed on a timely basis, regardless of which hospital the patient initially visits.[67]

Another failure is seen in the effect the new technology has had on the medical malpractice system.[68] Many physicians now refuse to perform certain services without such advanced technology for fear that the new technology will be deemed the legally required standard of care in a subsequent malpractice action.[69]

The final unusual market failure is that of institutional ego. This is comparable to patients wanting to be treated only in hospitals with the latest and best technology, except that it is the hospital that wants to be thought of as having that technology and not to be regarded as a second-class institution.[70] While one of the primary reasons for this overinvestment may be to attract certain patients, another reason for

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64. *Cf.* L. BROWN, *supra* note 22, at 11 (noting that patients insist on the latest and best medical resources).

65. *See* Preston, *The Federal Trade Commission's Identification of Implications as Constituting Deceptive Advertising*, 57 U. CIN. L. REV. 1243, 1285-88 (1989).

66. *See* FLA. ADMIN. CODE ANN. r. 10-5.011 (1990) (access standards for advanced tertiary services).

67. When regulators try to limit the number of facilities that offer advanced services, there arises an inherent tension with health care consumers who want easy access to all services, whether the regulators find a "need" or not. *See* Comment, *Certificate of Need for Health Care Facilities: A Time for Re-examination*, 7 PACE L. REV. 491, 529 ("While health care regulators seek to rationalize the health care system, health care consumers want to feel that when family members fall ill, they will have convenient access to the best and most technologically advanced medical care.").

68. *See* Furrow, *Medical Malpractice and Cost Containment: Tightening the Screws*, 36 CASE W. RES. L. REV. 985 (1986); Morreim, *Cost Containment and the Standard of Medical Care*, 75 CALIF. L. REV. 1719 (1987).

69. *See generally* Furrow, *supra* note 68.

70. L. BROWN, *supra* note 22, at 11.

the hospital to accumulate the latest and best technology might be to attract physicians to the facilities.[71] This is probably a result, at least in part, of the tort inefficiencies discussed above.[72]

B. *Today's Hospital Reimbursement Environment Eliminates Many of These Concerns*

When CON review initially gained widespread use during the early 1970s, the health care reimbursement market was significantly different than it is today. The intervening changes have had a dramatic impact in eliminating many of the cost containment concerns caused by the market imperfections discussed above[73] and have prompted one commentator to suggest that "the CON process is superfluous in the new reimbursement environment."[74]

The primary change has come in the way health care is financed. More than ninety percent of hospital costs today are paid by third parties such as the government and insurance companies.[75] Thus, any change in the way those third parties operate may have substantial effects on the entire hospital market. That is exactly what has happened.[76] When CON review was implemented nearly twenty years ago, third-party payment was made primarily using a "reasonable cost" method.[77] That method allowed providers to receive full reimbursement of their reasonable costs incurred in providing service.[78] The presumption was that all costs billed were "reasonable," and this meant that insurance companies paid virtually any bill that the hospitals prepared.[79]

Today, however, reimbursement is often made under a prospective payment method.[80] Under this method, the third-party payer typically determines in advance how much it will pay for the particular diagnosed needs of the patients it covers.[81] The prospective payment method encourages providers to develop the most economically effi-

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71. Simpson, *supra* note 3, at 1028-29 n.16.
72. *See supra* notes 68-69 and accompanying text.
73. Simpson, *supra* note 3, at 1079-80.
74. Shannon, *supra* note 8, at 595.
75. 1990 ATLAS, *supra* note 48, at 123 (1987 data).
76. *See infra* notes 80-97 and accompanying text.
77. Shannon, *supra* note 8, at 595.
78. *Id.*
79. *Id.*
80. Hamilton, *Barriers to Hospital Diversification: The Regulatory Environment*, 24 DUQ. L. REV. 425, 432-434 (1985); Simpson, *supra* note 3, at 1080. The prospective payment system was developed by those who finance health care as a response to spiralling costs. *See, e.g.*, 2 UNIVERSITY STUDY, *supra* note 1, at 1.9.
81. Hamilton, *supra* note 80, at 432-34.

cient means to provide those services because the hospital will generally receive a fixed sum, regardless of actual cost.[82] This system is regarded as so favorable for cost containment that the Florida Legislature has specifically encouraged it and has even required it in certain cases.[83] By placing the financial risks of excessive costs on the provider, hospitals are forced to evaluate more carefully capital expenditures along competitive economic lines, a practice that was not generally present when CON was initially developed.[84] Also, hospitals are encouraged to reduce actual cost per patient by "discharg[ing] patients as early as medically possible, . . . identify[ing] and eliminat[ing] the use of unnecessary tests and procedures, and utiliz[ing] lower cost outpatient services and freestanding facilities to the maximum extent possible."[85]

Because of the expansion of health maintenance organizations (HMOs) and preferred provider organizations (PPOs), third-party payers have recently gained even more economic bargaining power and greater control over the services their member patients receive.[86] The HMOs and PPOs seek to contain costs by limiting members' choice of health care providers to those with whom the organization has negotiated lower rates and by reviewing the members' use of services.[87] The PPOs do not strictly limit members' choice of providers, but they do offer financial incentives to members to use the preferred providers.[88] The providers who agree to serve the plans' members do so for fixed, predetermined rates that usually involve volume discounts.[89] Members are responsible for certain copayment percentages and deductibles, which are often less for PPO members who use the services of preferred providers.[90] Increased activism by third-party

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82. Simpson, *supra* note 3, at 1080.

83. FLA. STAT. § 407.13 (1989).

84. L. BROWN, *supra* note 22, at 17 ("A tight rein on prospective payment rates and adjustments may . . . offer the best of both worlds: a regulatory, price-fixing scheme with strong competitive implications. Perhaps in time the incentives of the system will encourage mergers, consolidations, and takeovers, thereby eliminating much of today's surplus capacity."); Shannon, *supra* note 8, at 595.

85. Hamilton, *supra* note 80, at 433. Some have argued that the effect of such changes is to decrease quality of care. However, at least some of those who raise the argument may have a strong self-interest in returning to the reasonable cost method and its higher reimbursement rates. *See* Gross, *supra* note 3, at 195 n.90 (information in article taken from a letter written by the executive vice president of the Arizona nursing home industry).

86. Simpson, *supra* note 3, at 1080.

87. 1990 ATLAS, *supra* note 48, at 132.

88. *Id.* at 134.

89. *Id.* at 132.

90. *Id.* at 134.

payers helps to control costs by forcing providers to act in an economically efficient manner.[91]

In addition to negotiating for lower fees, HMOs, PPOs, and other third-party payers intervene to control the actual usage of health care service by the patients they cover.[92] Such intervention typically involves requiring preapproval of nonemergency care and after-the-fact review of services provided in order to determine the necessity and propriety of such services.[93] This process of reviewing patient use allows for the denial of payment for medical care that is deemed unnecessary.[94]

The increasing use of copayments and deductibles in ordinary health insurance has also acted to decrease the moral hazard problem.[95] Insurers have adopted copayments and deductibles in response to the substantial economic literature that shows the moral hazard effect when near-100% insurance is available.[96] The more that patients have to pay when they receive care, the more likely they will be to examine more carefully whether such care is actually necessary.[97]

Another change in today's health care environment is not directly related to reimbursement methods, but has still had an impact on how hospitals have been forced to compete.[98] The increasing development of ambulatory surgical centers and other outpatient facilities has given hospitals competition where previously there was none.[99] Such competition is even more pronounced because due to the considerable savings that are usually involved, some third-party payers require that certain services be provided on an outpatient basis.[100] That outpatient facilities are generally exempt from CON requirements has undoubtedly also played a role in their development and competitiveness.[101]

C. *Empirical Literature Showing CON's Ineffectiveness at Cost Containment*

Given the tenuous economic grounds upon which CON was initially established and the subsequent changes in the way the hospital indus-

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91. *See id.* at 132.

92. *Id.*

93. L. BROWN, POLITICS AND HEALTH CARE ORGANIZATION, HMOs AS FEDERAL POLICY 174 (1983).

94. 1990 ATLAS, *supra* note 48, at 132.

95. *See* A. POLINSKY, *supra* note 13, at 56-57.

96. *See, e.g., id.*

97. *See id.*

98. 1990 ATLAS, *supra* note 48, at 114; L. BROWN, *supra* note 22, at 18.

99. *See* 1990 ATLAS, *supra* note 48, at 114; L. BROWN, *supra* note 22, at 18.

100. 1990 ATLAS, *supra* note 48, at 114; Hamilton, *supra* note 80, at 433. Also, some insurers provide strong economic incentives for their insureds to use outpatient services. For example, an insurer may pay 100% of the cost of an outpatient procedure, but will require a 20% copayment if the service is performed on an inpatient basis.

101. *See* FLA. STAT. § 381.706(1)(c) (1989).

try has been forced to operate, it comes as little surprise that CON may not be accomplishing its primary goal of cost containment. An in-depth, statistically valid study is not required to recognize that hospital costs have continued to spiral since the early days of CON.[102] The question is whether CON has had a moderating effect on this trend, and research shows that it has not.[103]

One survey of the empirical literature on CON and cost containment has found that "[r]esearch on this form of hospital regulation has produced remarkably consistent results. The empirical evidence indicates that certificate-of-need laws have not been successful in restraining per diem, per case, or per capita hospital costs."[104] In one comparison of health care prices and expenses, it was shown that such prices and expenses are actually higher in areas with CON regulations than they are in areas without CON.[105] Also, some researchers believe that the primary effects of CON laws are less efficient resource use and higher costs.[106]

Despite the strong support it enjoyed at its inception and still enjoys in some circles in Florida,[107] CON "has elicited a remarkable evaluative consensus—that it does not work."[108] In fact, to the extent that cost containment remains a regulatory goal, it seems that CON is not the means to achieve that goal.[109] Rather, changes in the economic environment in which hospitals operate seem to be the best means of accomplishing the goal of cost containment. A letter from the staff of the Federal Trade Commission stated that

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102. In fact, national expenditures for hospital care have climbed from $52.4 billion in 1975 when the federal government enacted NHPRDA to an estimated $230.1 billion in 1989. 1990 ATLAS, *supra* note 48, at 109.

103. At least one commentator suggests that the results of these studies may be unreliable because of "inherent methodological flaws." Gross, *supra* note 3, at 191. However, Mr. Gross was apparently unable to provide contradictory evidence to show that CON programs do contain costs.

104. Steinwald & Sloan, *Regulatory Approaches to Hospital Cost Containment: A Synthesis of the Empirical Evidence*, in A NEW APPROACH TO THE ECONOMICS OF HEALTH CARE 274, 285 (1981).

105. Shannon, *supra* note 8, at 593 (citing M. NOETHER, COMPETITION AMONG HOSPITALS (1987) (Federal Trade Commission Staff Report)).

106. *Id.*

107. *See, e.g.*, Gross, *supra* note 3.

108. Brown, *supra* note 7, at 481.

109. Coase argued that government decision making is often an inappropriate means of allocating resources that are subject to market forces. The reason is twofold:

> First of all [the government] lacks the precise monetary measure of benefit and cost provided by the market. Second, it cannot, by the nature of things, be in possession of all the relevant information possessed by the managers of every [relevant] business . . . to say nothing of the preferences of consumers for the various goods and services [in question].

Coase, *The Federal Communications Commission*, 2 J.L. & ECON. 1, 18 (1959).

> [o]ngoing improvements in health care financing are resolving the principal problems that prompted CON regulation. Moreover, the benefits of CON regulation, if any, are likely to be outweighed by its adverse effects on competition in health care markets. Consequently, CON regulation is likely to harm consumers on balance by increasing the price of health care services. . . .[110]

Overall, "[t]he current evidence . . . suggests that certificate-of-need controls . . . may be regarded as a classic example of regulatory failure."[111]

III. INDIGENT CARE

The concepts of CON, cost containment, and indigent care are interrelated. In addition to cost containment, one of the stated goals of CON is ensuring adequate care to Florida's indigent population.[112] Nonetheless, a report commissioned and conducted by the state found that its cost containment approaches are actually contributing to the state's indigent care problem.[113] Because of the increasing indigent care burden on Florida's hospitals,[114] it is necessary to examine the current system for the provision and financing of such care to determine whether it is adequate. If not, the system should be changed.

A. The Current System

In Florida there are essentially two parts to the current system of indigent care. The first part comes in determining to whom CONs will be awarded; facilities that provide large amounts of indigent care are favored. The second part involves a system of taxes and fees that are redistributed to indigent care providers as partial compensation for care that would otherwise go uncompensated.

One of the review criteria established by the Florida Legislature for the award of CONs is "[t]he applicant's past and proposed provision

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110. Shannon, *supra* note 8, at 596 (quoting a letter from John J. Mendenhall to Michigan Representative Gerald H. Law (March 7, 1988)).

111. Steinwald & Sloan, *supra* note 104, at 296.

112. *See* Simpson, *supra* note 3, at 1083-84.

Indigent patients are generally defined as those "whose ability to pay for health care is limited by poverty, lack of insurance, or a catastrophic illness." 1990 ATLAS, *supra* note 48, at 138.

113. UNIVERSITY STUDY, *supra* note 1, at 1.2.

This result may be argued as being atypical based on the argument that "[r]egulation is often beneficial to the regulated firms." McCormick, *The Strategic Use of Regulation: A Review of the Literature*, in THE POLITICAL ECONOMY OF REGULATION: PRIVATE INTERESTS IN THE REGULATORY PROCESS 13, 18 (Federal Trade Commission Law & Economics Conference 1984).

114. 1989 PLAN, *supra* note 1, at 31.

of health care services to Medicaid patients and the medically indigent."[115] Additionally, preference in CON awards is to be given to those applicants who "ensure access to emergency and other health care services for all Floridians without regard to their economic status . . . [and] [p]roviders who serve a disproportionate number of charity and Medicaid patients and who propose to provide services in underserved areas or to specific populations in need."[116] Presumably, these preferences require Florida's Department of Health and Rehabilitative Services (HRS) to weight the balance in favor of the indigent care provider.[117] Because no indication is given by the Legislature or in the administrative rules, however, it is unclear exactly how much weight is to be given to this or any other single factor.[118]

The advantage of preference in the CON awards for Florida's indigent care providers (ICPs) is that it allows the ICPs to offer certain sophisticated services without competition that may otherwise exist from nonICPs. The lack of competition draws many of the paying patients to the ICPs, helping those providers cross-subsidize their indigent care services.[119] This wealth-transferring policy has rich sick people paying to care for poor sick people. Such cost-shifting has become more difficult in recent years as third-party payers have reformed their systems of reimbursement and have refused to participate in financing care for patients other than their own.[120]

If the more "glamorous" nonICPs are permitted to add new services and technology, those nonICPs may skim the cream from the indigent providers.[121] That is, the patients who can pay, once given a choice, may use the upper-scale nonICPs, leaving the ICPs with only the indigents and hence, an insufficient number of paying patients to allow for overall profitability. The lack of profitability may lead to the failure of ICPs and leave a significant portion of the population without ready access to health care. While cream skimming is usually

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115. FLA. STAT. § 381.705(1)(n) (1989).

116. 1989 PLAN, *supra* note 1, at 4.

117. The Office of Community Health Services and Facilities within HRS is responsible for reviewing and analyzing CON applications and for issuing and denying CONs. FLA. ADMIN. CODE ANN. r. 10-5.003 (1991).

118. *See* Collier Medical Center v. Department of HRS, 462 So. 2d 83, 84 (Fla. 1st DCA 1985) ("[T]he appropriate weight to be given to each individual criterion is not fixed, but rather must vary on a case-by-case basis, depending upon the facts of each case.").

119. *See* Makar, *supra* note 23, at 155; Ponsoldt, *Immunity Doctrine, Efficiency Promotion, and the Applicability of Federal Antitrust Law to State-Approved Hospital Acquisitions*, 12 J. CORP. L. 37, 40 (1986).

120. 1989 PLAN, *supra* note 1, at 31; UNIVERSITY STUDY, *supra* note 1, at 1.2.

121. *See* Ponsoldt, *supra* note 119, at 40. *See generally* A. KAHN, THE ECONOMICS OF REGULATION: PRINCIPLES AND INSTITUTIONS 220-246 (1971).

economically efficient, it may result in undesirable effects on social welfare, as here.[122]

The second major element of Florida's policy for the provision of indigent care is based on an assessment paid into the Public Medical Assistance Trust Fund (PMATF).[123] The PMATF was originally established in 1984 under the Health Care Access Act[124] to reimburse hospitals for uncompensated care.[125] The PMATF is funded through a 1.5 percent surcharge on all hospital revenues,[126] and the state has also contributed a total of $30 million from its general fund since the PMATF was created.[127] The fund is administered by the Medicaid program and is therefore eligible for matching federal funds.[128] The PMATF has allowed indigent care providers to receive considerably more revenue than they would have otherwise, but it is facing increasing operating deficits.[129] For fiscal year 1990-91, the estimated deficit was $219 million.[130]

Operating deficits prompted attempts during the 1991 Legislative Session by the Governor and members of the Legislature to increase the assessment that it charges hospitals,[131] but no legislation was actually passed.[132] Currently all hospitals are subject to an assessment of

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122. *See* A. KAHN, *supra* note 121, at 220-246.

123. 1990 ATLAS, *supra* note 48, at 138.

124. 1984 Fla. Laws 52; 1990 ATLAS, *supra* note 48, at 138.

125. 1990 ATLAS, *supra* note 48, at 138. In the intent portion of the statute that established the PMATF, the Legislature said:

> It is declared that access to adequate health care is a right which should be available to all Floridians. However, rapidly increasing health care costs threaten to make such care unaffordable for many citizens. The Legislature finds that unreimbursed health care services provided to persons who are unable to pay for such services cause the cost of services to paying patients to increase in a manner unrelated to the actual cost of services delivered. Further, the Legislature finds that inequities between hospitals in the provision of unreimbursed services prevent hospitals that provide the bulk of such services from competing on an equitable economic basis with hospitals that provide relatively little care to indigent persons. Therefore, it is the intent of the Legislature to provide a method for the [sic] funding the provision of health care services to indigent persons, the cost of which should be borne by the state and by the hospitals that are granted the privilege of operating in this state.

Ch. 282, 1991 Fla. Sess. Law Serv. 2165 (West) (renumbering and amending FLA. STAT. § 409.918 (1989)).

126. FLA. STAT. § 395.101 (1989 & Supp. 1990).

127. Ch. 91-282, 1991 Fla. Sess. Law Serv. 2165 (West) (renumbering and amending FLA. STAT. § 409.918 (1989)).

128. 1990 ATLAS, *supra* note 48, at 138.

129. *Id.*

130. *Id.* Faced with this information, the 1991 Legislature could have adopted a long-term strategy for dealing with the indigent care problem, but it declined to do so.

131. *See* Tallahassee Democrat, Apr. 22, 1991, at 1A, col. 1; Tallahassee Democrat, April 22, 1991, at 1C, col. 4.

132. The Legislature did extend the 1.5% assessment to other types of health care entities for

1.5 percent of revenues.[133] Schemes suggested by the Governor and the Legislature would have had hospitals pay as much as 3.5 percent of their revenues into the PMATF.[134] That our government leaders believe that such an increase in assessments may be necessary tends to indicate that there are fundamental problems with the system of financing indigent care in Florida.

B. Recommendations

The fundamental problems in managing the escalating indigent care problem[135] in the current regulatory environment are that health care is expensive, and the current system allows only three inadequate alternatives for financing indigent care. The first alternative is to force hospitals to absorb the costs of providing indigent care and pass those costs on to paying patients.[136] As has been discussed, though, the major third-party payers have gotten more involved in the process and have refused to participate in such cross-subsidization.[137] The second alternative is direct governmental support of ICPs through a system of taxation. However, a plan increasing the burden on taxpayers is destined to fail in Florida, given the state's limited tax base under the current system of taxation.[138] The third alternative is to charge all hospitals a fee to be paid into a fund such as the PMATF and to use the proceeds to subsidize indigent care.[139] As has been seen with the PMATF, the assessment would have to be a significant percentage of hospitals' operating revenues. Otherwise, such a fund would not be sufficient to accomplish its goals.[140] There is doubt about whether the hospital industry is financially healthy enough to afford such increased assessments.[141]

Because of the lack of satisfactory alternatives that the current regulatory environment allows, it is appropriate to redefine the regulatory environment to allow for new approaches to financing indigent care in Florida.[142] This Comment proposes that the goal of financing

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contribution to the PMATF. Ch. 91-112, 1991 Fla. Sess. Law Serv. 903 (West) (to be codified at FLA. STAT. § 395.1015).

133. *See* Tallahassee Democrat, *supra* note 131, at 1C, col 4; FLA. STAT. § 395.101 (1989).

134. *See* Tallahassee Democrat, *supra* note 131, at 1C, col 4.

135. 1990 ATLAS, *supra* note 48, at 138 (indigent care is called "[a] growing crisis").

136. *See supra* note 119 and accompanying text.

137. *See supra* note 120 and accompanying text.

138. *See generally* Comment, *The Taxation and Budget Reform Commission: Florida's Best Hope for the Future*, 18 FLA. ST. U.L. REV. 437 (1991).

139. *See supra* notes 123-130 and accompanying text.

140. 1990 ATLAS, *supra* note 48, at 138-39.

141. *See Florida Hospitals*, *supra* note 29.

142. Using regulation to help correct for various market failures is based on a public interest model of regulation. *See* McCormick, *supra* note 113, at 17.

indigent care can be accomplished best by redefining the regulatory environment in such a way that market forces will determine how to pay for such care. The redefined system will also address the two other major goals of the current CON program—cost containment and quality control—at least as well as the current system does.

The suggestions made below to encourage cooperative agreements among health care providers and between providers and third-party payers should help further eliminate the market failures at work in the hospital industry and allow for greater cost containment. When the suggestions below are combined with the increased power of third-party payers, hospital costs should be contained to an economically efficient level. Quality control will still be guaranteed because the system of licensure and inspection by HRS will be continued in its current form.[143]

1. Redefine the Notion of CON

There are several elements to the proposed plan for restructuring the regulatory environment. First, the process and the purpose[144] of CON must be redefined.[145] Under the new system, a provider would still have to have a CON before it could establish new services,[146] but the process of issuing CONs and determining who receives them would be changed. The initial property right for any CON would be given to the ICPs[147] in the affected service area.[148] The ICPs would then have several options.

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143. *See* FLA. STAT. §§ 395.001-.104 (1989 & Supp. 1990); FLA. ADMIN. CODE CH. 10D-28 (1986).

144. The new system requires us to reevaluate the goals of CON. Because the cost of health care is not favorably affected by the CON program, the redefined program would concentrate on financing indigent care more efficiently. Other structural changes in the nonCON regulatory environment will address some of the other traditional concerns of CON, including cost containment.

145. Some of the elements of this proposal are suggested by Coase, *supra* note 109, in his discussion of the Federal Communications Commission.

146. Beds can be removed from CON limitations because of recommendations concerning the deregulation of beds. *See infra* notes 168-184 and accompanying text.

147. Designation as an ICP would need to be defined based on past levels of indigent care and conditioned on future provision of care at or above those levels.

Obviously, the details proposed in this overall framework may need to be modified depending on the precise nature of the individual competitive market and the number of indigent care providers in a service area. This will be particularly important because the state's indigent care population tends to be concentrated in certain geographic areas. *See* UNIVERSITY STUDY, *supra* note 1, at 1.15. However, the purpose of this Comment is not to draft precise legislation but to recommend a new framework for consideration by the Legislature.

148. The mere giving of this valuable property right without charge naturally raises the income of the ICP above what it would otherwise be. *See* Coase, *supra* note 109, at 22.

If an ICP determined that the greatest economic value of the CON would result from operating the service authorized, then the ICP could choose to exercise its CON. The decision would be based on ordinary economic considerations such as demand for the service, ability to attract paying patients, competitive environment, complementary services already existing at the facility or nearby facilities, and costs of operation, including necessary changes to the existing plant and staffing.[149]

If the ICP determined that the greatest economic value of the CON lay in the price that other nonICPs were willing and able to pay for the CON property right, then the ICP could sell the CON to the highest bidder.[150] The CONs under this new system would, of course, be freely transferable by any holder.[151] The nonICP would make its decisions about the extent to which it valued the property right embodied in the CON by considering essentially the same factors as would the ICP.[152]

There are two major advantages to this redefined system of CON. First, the free transferability will allow the property right to arrive in the hands of the highest-valuing user, a fundamental concept of economic efficiency.[153] By giving the initial property right to the ICPs, the balance of economic rights is weighted in favor of the ICPs and the state can favor the ICPs by compensating for wealth effects[154] without violating sound economic principles.[155] The second major advantage is that the ICP is given the flexibility to determine how best to use the resources available to it.[156] If the ICP determines that surrounding economic conditions indicate that operation of the service

149. Of course, any provider would still have to meet applicable quality and licensure standards. This would alleviate the concern of those who believe that CON is still important for its role in ensuring quality of care. *See* Simpson, *supra* note 3, at 1082-83.

150. The possible value of the CON would be further increased because of the recommended policy of encouraging combinations and cooperative agreements discussed below. *See infra* notes 157-164 and accompanying text.

151. The current CONs are transferrable with permission of HRS, but making a profit on such transfer is a criminal offense punishable by fine and imprisonment. FLA. STAT. § 381.712 (1989). Obviously, no such limitation would be present under the proposed scheme.

152. It is important to note that nonICPs that operate a service not provided by a reasonably accessible ICP will have to provide a certain amount of indigent care. This factor must be considered by the nonICP in determining the extent to which it values the property right embodied in the CON.

153. *See, e.g.*, Coase, *supra* note 109.

154. *See supra* note 13; A. POLINSKY, *supra* note 13, at 136.

155. Of course, it is possible that the CON will not always be put to its most efficient use because of transaction costs. Coase, *supra* note 109, at 27 n.54.

156. *See* Makar, *supra* note 23, at 157 ("Despite the efforts of health-planning agencies to predict and provide guidance on future health care trends, reliance on market forces provides greater flexibility in adapting to fluctuating market conditions.").

authorized by the CON would allow for the greatest profitability and possibilities for cross-subsidization, then the ICP can choose to take that route. If, on the other hand, the greatest value of the CON to the ICP is the price that other facilities are willing to pay to purchase the CON, then the ICP can sell the CON and use the profits from the sale to finance other services it provides to indigent patients.

2. *Encourage Cooperative Agreements Among Hospitals and Between Hospitals and Private Payers*

One of the market failures at work in the current system is the perceived potential for excessive competition.[157] Along with some of the other market imperfections, including the inefficient incentives to overspend for certain services,[158] this failure leads to a recommendation that the government encourage combinations and cooperative agreements among health care providers.[159] Currently, many hospitals view themselves as needing to be full service hospitals offering all major services and having sufficient resources to support that arrangement, even though there may be another hospital nearby that offers exactly the same services.[160] This view results in a large amount of wasteful redundancy.[161] A solution, therefore, would be to allow hospitals to jointly operate certain services for which there is not enough actual demand to support multiple services, but for which the market imperfections demand that each hospital have ready access.[162] Fears that these hospitals may engage in monopoly pricing are addressed by the increasing intervention and market power of third-party payers who could effectively prevent excessive price gouging.

Encouraging joint operations will also allow for greater effectiveness of the proposal to give ICPs the initial property rights in CONs and allow them to freely transfer those rights to the highest-valuing user. By encouraging combinations, the value placed on certain services may be increased. For example, an ICP may determine that it values a particular CON highly, but not highly enough to warrant exercising it by itself, and there may be other nonICPs who place similar values on the CON. By allowing the ICP to operate services jointly

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157. *See supra* notes 35-43 and accompanying text.

158. *See supra* notes 63-72 and accompanying text.

159. Such encouragement may require providing certain exemptions from antitrust laws.

160. *See supra* notes 63-72 and accompanying text.

161. *Id.*

162. See Hamilton, *supra* note 80 for the argument that one of the major flaws of CON is that it acts as a barrier to such efficiency-increasing arrangements.

Such cooperative agreements are already being used to some extent. For example, mobile lithotripters are being shared by several facilities in Florida.

with other facilities, or by allowing it to sell the CON to a group of other facilities, the overall value placed on the right will be maximized. Maximizing the CON value allows the total value to society to be maximized and also ensures that the ICPs receive the greatest subsidies.

Another important benefit of encouraging these arrangements is that combinations between urban ICPs and suburban nonICPs will allow for more direct cross-subsidization of the uncompensated care provided by the urban ICPs. Because much of Florida's indigent population is located in urban areas, some of Florida's inner-city hospitals provide a disproportionate amount of indigent care.[163] Some of these inner-city hospitals believe it is necessary to establish satellite facilities in suburban areas "to attract paying patients and subsidize charity care costs."[164] Cooperative agreements between both types of facilities would give suburban nonICPs access to services for which the ICP was issued the CON property right, and they would give inner-city ICPs access to pre-existing suburban revenue-generating facilities. These transactions presumably could be accomplished at a lower cost than would be required for the nonICPs to purchase the CON from the ICP or for the ICP to build or purchase a satellite facility.

Also, relationships should be encouraged between health care providers and third-party payers who actually finance the care.[165] Encouraging more active relationships between the hospitals and the third-party payers should further decrease the moral hazard problem. The institutional participants, in conjunction with the third-party payers, will work to eliminate incentives and opportunities for patients to choose their health care in an economically irresponsible manner. An active relationship between the hospitals and the third-party payers will also increase incentives for efficiency.[166] By placing a strong fi-

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163. 1989 PLAN, *supra* note 1, at 26.

164. *Id.*

165. Previously there was a legislative exemption from the CON regulations for hospitals controlled by HMOs. FLA. STAT. § 381.713(1) (1989). The Legislature removed the exemption for HMOs in the 1991 legislative session. Ch. 91-282, 1991 Fla. Laws 2610. Skeptics charge that the Legislature removed the exemption in response to lobbying by competitors of Florida's largest HMO, Humana, and also in response to HRS's institutional objectives of protecting existing providers and protecting the power of the agency. *See* 1990 ATLAS, *supra* note 48, at 134. This type of turf protection by an agency is not unusual in light of bureaucratic models claiming that regulation proceeds to maximize the size of the bureaucracy. *See* McCormick, *supra* note 113, at 20 n.19.

166. L. BROWN, *supra* note 22, at 45-46: "[A]ccessible care of acceptable quality can be harmonized with the containment of costs in any system with extensive third-party payment only if payers (public, private, or both) build stable negotiating structures with providers."

nancial emphasis on the provision of health care, costs eventually will be lowered and economic efficiency eventually will be improved.[167]

3. *Deregulate Beds*

Because of the huge surplus of hospital beds already existing in Florida, hospital beds must be treated differently than services. While the scheme proposed in this Comment would still regulate entry into new service areas, no such barriers should exist for the addition, removal, or conversion of hospital beds.

There are several reasons for this huge surplus of beds. First, as third-party payers have implemented prospective payment mechanisms, the number of admissions and the average length of stay have decreased.[168] The surplus may be further evidence of the far-reaching impact that the increasing intervention of the government and of private insurers is having. Another major reason for the decreased use of inpatient hospital beds[169] is the increased use of outpatient facilities.[170] The increased use of outpatient facilities is expected to continue as technological advances allow more procedures to be performed on an outpatient basis.[171] It is significant from the third-party payers' perspective that the outpatient treatment alternative is generally less expensive than inpatient care, and it is significant from the hospitals' perspective that Florida does not require a CON to establish outpatient facilities.

The health planners at HRS have determined that the optimum desirable occupancy rate for acute care hospital beds is seventy-five percent.[172] A recent report by HRS showed the actual statewide occupancy average to be 52.7%,[173] resulting in an excess of 15,722 beds.[174] The fixed and operating expenses associated with these excess beds result in an estimated annual cost of between $64.6 million and $1.6 billion, depending on the study used.[175] Based on this tremendous excess and forecasts for future usage, "bed need projections have been zero for several years,"[176] and it is estimated that if no more beds

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167. Continued licensure standards and the constant supervision of the medical malpractice system will ensure that quality of care is not sacrificed in the name of economic savings.

168. 1989 PLAN, *supra* note 1, at 20.

169. General care inpatient hospital beds are usually known as acute care beds. FLA. ADMIN. CODE ANN. r. 10-5.002(2) (1991).

170. 1989 PLAN, *supra* note 1, at 22.

171. *Id.*

172. FLA. ADMIN. CODE ANN. r. 10-5.038(e) (1991); 1989 PLAN, *supra* note 1, at 16.

173. 1989 PLAN, *supra* note 1, at 20.

174. *Id.*

175. *Id.* at 23.

176. *Id.* at 16.

are added to the system, Florida will not reach the seventy-five percent occupancy standard until after the year 2010.[177] These unused assets are cited by some as one of the primary reasons for the financial difficulties of many hospitals.[178]

Hospital beds should be deregulated, and hospitals should be allowed to add, remove, and change the status of beds as the market dictates. This will allow hospitals to use existing beds for more than just the narrow uses that the law currently allows.[179] Currently, if a hospital has 100 beds licensed for acute care patients and half of those beds remain unused, there are no real alternative uses to which the hospital can put those beds.[180] Also, if that hospital determines that the space and resources demanded by those unused beds would be put to better use in some other way, it must apply for a CON to delicense those beds.[181] Thus, there is considerable waste, and some hospitals cite this factor as a major one in their decreasing profits.[182]

The deregulation proposed will allow the hospitals to vary bed usage depending on how the needs of a community differ over time and what the market demands. For example, the hospital described above could—if it had adequately trained personnel—use some of those fifty unused beds for demanded income-generating psychiatric, substance abuse, or rehabilitation services.[183] Giving the hospitals the authority to make those determinations and to add or remove beds as appropriate will increase long-term efficiency.

The resulting increased efficiency from deregulating the use of hospital beds will help finance indigent care in two ways. First, it will directly benefit ICPs by allowing them to use all their resources in the most economically efficient way. Second, it will allow nonICPs to operate more efficiently and increase overall profitability.[184] Both events will place nonICPs in stronger financial positions and therefore increase the amounts they are able to offer to purchase the property rights to CONs from the ICPs.

IV. CONCLUSION

The CON program, as initially conceived and currently implemented, has a primary goal of containing health care costs and a sec-

177. *Id.* at 23.

178. *See supra* note 113 and accompanying text; *Florida Hospitals*, *supra* note 29.

179. HRS has said that hospitals should be encouraged to use excess beds for alternative purposes, but under that proposal HRS would still have to license and authorize those alternative purposes. 1989 PLAN, *supra* note 1, at 25.

180. *See* FLA. STAT. § 381.706(1)(a), (e) (1991).

181. FLA. STAT. § 381.706(1)(e) (1991).

182. *See Florida Hospitals*, *supra* note 29.

183. *See* 1989 PLAN, *supra* note 1, at 25.

184. *Id.*

ondary goal of ensuring adequate indigent care. The first goal is not achieved, and the second goal is not efficiently or adequately achieved.

The economic environment for hospitals has changed dramatically since the early years of CON, and the empirical literature is virtually unanimous in its findings that CON has been ineffective at controlling costs. In light of these developments the federal government and several states have abandoned their CON programs, yet Florida has neither abandoned its program nor made meaningful substantial changes. It is time for Florida to abandon its CON program as a tool for cost containment. There is no real evidence that it is effective, and there is ample evidence that it is actually exacerbating the problems of the hospital marketplace.

The CON program may have some usefulness as a tool for ensuring adequate indigent care through protection of indigent care providers. The significant financial woes of the system designed to finance indigent care indicate, however, that CON is not accomplishing that goal. The CON program should be redefined to better accomplish the social goal of financing indigent care. By giving indigent care providers the property rights to exercise or sell CONs, and by allowing continued free transfer of CONs, market forces will help determine how best to provide compensation for the ICPs. This fundamental change, combined with other steps to make the hospital industry more efficient as a whole, will strengthen the system of indigent care in Florida, and will, as a pleasant side effect, strengthen the entire hospital market in the long run.